



# RULE-MAKING ORDER

**CR-103 (June 2004)**  
(Implements RCW 34.05.360)

Agency: Insurance Commissioner

☒ Permanent Rule  
☐ Emergency Rule

**Effective date of rule:**

**Permanent Rules**

☒ 31 days after filing.  
☐ Other (specify) \_\_\_\_\_ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

**Effective date of rule:**

**Emergency Rules**

☐ Immediately upon filing.  
☐ Later (specify) \_\_\_\_\_

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**

☐ Yes ☒ No If Yes, explain:

**Purpose:** These new rules follow the general format of the NAIC model regulation to allow for greater consistency in the implementation of coordination of benefit standards.

Insurance Commissioner Matter No. R 2005-07

**Citation of existing rules affected by this order:**

Repealed: 284-51-010, 284-51-115, 284-51-020, 284-51-030, 284-51-040, 284-51-045, 284-51-050, 284-51-060, 284-51-075, 284-51-080, 284-51-090, 284-51-100, 284-51-110, 284-51-120, 284-51-130, 284-51-140, 284-51-150, 284-51-170, 284-51-185

Amended: \_\_\_\_\_

Suspended: \_\_\_\_\_

**Statutory authority for adoption:** RCW 48.20.60, 48.21.200, 48.44.050, and 48.46.200

**Other authority :**

**PERMANENT RULE ONLY (Including Expedited Rule Making)**

Adopted under notice filed as WSR 07-07-125 on March 21, 2007 (date).

Describe any changes other than editing from proposed to adopted version:

1. WAC 284-51-195(1) – clarification that a secondary plan is not required to pay an amount in excess of its maximum benefit plus accrued savings. Additional clarification that Medicare applies to Part A and Part B or Part C.
2. WAC 284-51-195(12)(c)(xi) - Language modified to reflect that "plan" does not include benefits provided as part of a direct agreement with a direct patient-provider primary care practice, as defined at section 3, chapter 267, Laws of 2007.
3. WAC 284-51-200(3) – Clarification that Appendix language changes are permissible that don't conflict with rule.
4. WAC 284-51-200(7) – "Plan year" changed to "claim determination period," consistent with other references in rule.
5. WAC 284-51-230(1) – Eliminated non-essential language that was confusing and inconsistent with claim adjudication.
6. WAC 284-51-235 – Reference to "explanation of benefits" changed to "enrollee contract or booklet."
7. WAC 284-51-235 – Changed "will" to "may" since Medicare does not always submit claims to the secondary carrier.
8. WAC 284-51-255 Section D (4) – Eliminated language inconsistent with the underlying definition of "Allowable Expense."
9. WAC 284-51-255 & 260 – Modifications to both for consistency with the change to WAC 284-51-195 relative to the payment obligations of the secondary plan.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: \_\_\_\_\_ phone ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ fax ( ) \_\_\_\_\_  
e-mail \_\_\_\_\_

**EMERGENCY RULE ONLY**

Under RCW 34.05.350 the agency for good cause finds:

- ☐ That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.
- ☐ That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding:

**Date adopted:**

June 8, 2007

**NAME (TYPE OR PRINT)**

Mike Kreidler

**SIGNATURE**

*Mike Kreidler*

**TITLE**

Insurance Commissioner

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

DATE: June 08, 2007  
TIME: 8:49 AM

WSR 07-13-008

(COMPLETE REVERSE SIDE)

**Note: If any category is left blank, it will be calculated as zero.  
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.  
A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

<b>Federal statute:</b>	New	_____	Amended	_____	Repealed	_____
<b>Federal rules or standards:</b>	New	_____	Amended	_____	Repealed	_____
<b>Recently enacted state statutes:</b>	New	_____	Amended	_____	Repealed	_____

**The number of sections adopted at the request of a nongovernmental entity:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted in the agency's own initiative:**

New	<u>15</u>	Amended	_____	Repealed	<u>19</u>
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**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted using:**

<b>Negotiated rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Pilot rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Other alternative rule making:</b>	New	<u>15</u>	Amended	_____	Repealed	<u>19</u>

#### NEW SECTION

**WAC 284-51-190 Purpose.** (1) The purpose of this chapter is to:

(a) Establish a uniform order of benefit determination under which plans pay claims;

(b) Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, under rules established by this chapter, do not have to pay their benefits first; and

(c) Provide greater efficiency in the processing of claims when a person is covered under more than one plan.

(2) This chapter does not require the use of coordination of benefits provisions in a plan. However, if a plan contains any provision for the reduction of benefits payable because of other insurance, it must be consistent with the requirements of this chapter. A plan of coverage designed to be supplementary over the underlying basic plan of coverage may provide coverage that is excess to the basic plan of coverage.

#### NEW SECTION

**WAC 284-51-195 Definitions.** As used in this chapter, these words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) "Allowable expense," except as outlined below means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person. When coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, totals the higher of the allowable expenses. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A and Part B or Part C are primary, Medicare's allowable amount is the highest allowable expense.

(a) If an issuer is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established according to Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

(b) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

(c) The following are examples of expenses that are not allowable expenses:

(i) If a person is confined in a private hospital room, the difference between the cost of a semiprivate room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(ii) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

(iii) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

(d) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense must include similar expenses to which COB applies.

(e) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(2) "Birthday" refers only to the month and day in a calendar year and does not include the year in which the individual is born.

(3) "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

(a) Services (including supplies);

(b) Payment for all or a portion of the expenses incurred;

(c) A combination of (a) and (b) of this subsection; or

(d) An indemnification.

(4) "Claim determination period" means calendar year.

(5) "Closed panel plan" means a plan that provides health benefits to covered persons in the form of services primarily through a panel of providers that are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(6) "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation according to federal law.

(7) "Coordination of benefits" or "COB" means a provision establishing the order that plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

(8) "Custodial parent" means:

(a) The parent awarded custody of a child by a court decree;  
or

(b) In the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation; or

(c) In cases where a court decree awards more than half of the calendar year's residential time to one parent without the use of "custodial" terminology, the parent to whom the greater residential time is awarded.

(9) "High-deductible health plan" has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(10)(a) "Hospital indemnity benefits" or "hospital fixed payment plan" means benefits not related to expenses incurred.

(b) "Hospital indemnity benefits" or "hospital fixed payment plan" does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(11) "Issuer" means a disability carrier, health care service contractor, health maintenance organization, and any other entity issuing a plan as defined in this chapter.

(12) "Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

(a) If a plan coordinates benefits, its contract must state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subsection.

(b) "Plan" includes:

(i) Group, individual or blanket disability insurance contracts, and group or individual contracts marketed by issuers as defined in this chapter;

(ii) Closed panel plans or other forms of group or individual coverage;

(iii) The medical care components of long-term care contracts, such as skilled nursing care; and

(iv) Medicare or other governmental benefits, as permitted by law, except as provided in (c)(vii) of this subsection. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(c) "Plan" does not include:

(i) Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;

(ii) Accident only coverage;

(iii) Specified disease or specified accident coverage;

(iv) Limited benefit health coverage, as defined in WAC 284-50-370;

(v) School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(vi) Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(vii) Medicare supplement policies;

(viii) A state plan under Medicaid;

(ix) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan;

(x) Automobile insurance policies required by statute to provide medical benefits;

(xi) Benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined at section 3, chapter 267, Laws of 2007.

(13) "Policyholder" means the primary insured named in a nongroup insurance policy.

(14) "Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan subject to this chapter is a primary plan if:

(a) The plan either has no order of benefit determination rules, or its rules differ from those permitted by this chapter; or

(b) All plans that cover the person use the order of benefit determination rules required by this chapter, and under those rules the plan determines its benefits first.

(15) "Secondary plan" means a plan that is not a primary plan.

#### NEW SECTION

**WAC 284-51-200 Use of model COB contract provision.** (1) WAC 284-51-255, Appendix A contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of subsections (2), (3), and (4) of this section and to the provisions of this chapter.

(2) WAC 284-51-260, Appendix B is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. It is not intended to replace or change the provisions that are in the contract. Its purpose is to explain the process to be used by two or more plans to pay for or provide benefits as allowed by the provisions of this chapter.

(3) Issuers need not use the specific words and format provided in WAC 284-51-255 and the plain language explanation in

WAC 284-51-260. Editing changes may be made by the issuer to fit the language and style of the rest of its contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. Modifications may be made provided they do not conflict with the requirements of this chapter.

(4) A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

(a) Another plan exists and the covered person did not enroll in that plan;

(b) A person could have been covered under another plan; or

(c) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

(5) No plan may contain a provision that its benefits are "always excess" or "always secondary" except under the rules permitted in this chapter.

(6) No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan as defined in this chapter.

(7) If a person has met the requirements for coverage under the primary plan, a closed panel plan in secondary position must pay benefits as if the covered person had met the requirements of the closed panel plan. Further, coordination of benefits may occur during the claim determination period even where there are no savings in the closed panel plan.

#### NEW SECTION

**WAC 284-51-205 Rules for coordination of benefits.** (1) When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

(b) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(c) When multiple contracts providing coordinated coverage are treated as a single plan under this chapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one issuer pays or provides benefits under the plan, the issuer designated as primary within the plan is responsible for the plan's compliance with this chapter.

(d) If a person is covered by more than one secondary plan, the order of benefit determination rules of this chapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this chapter, has its benefits determined before those of that secondary plan.

(2) (a) Except as provided in (b) of this subsection, a plan that does not contain order of benefit determination provisions that are consistent with this chapter is always the primary plan unless the provisions of both plans, regardless of the provisions of this section, state that the complying plan is primary.

(b) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples include major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(3) A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this chapter, it is secondary to that other plan.

(4) Order of benefit determination. Each plan determines its order of benefits using the first of the following rules that applies:

(a) Nondependent or dependent.

(i) Subject to (a)(ii) of this subsection, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(ii) (A) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g., a retired employee);

(B) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(b) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child must determine the order of benefits as follows:

(i) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(A) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(B) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.



(ii) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(A) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision;

(B) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(C) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (b) (i) of this subsection determine the order of benefits;

(D) If a court decree states that the parents have joint custody without specifying that one parent has financial responsibility or responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (b) (i) of this subsection determine the order of benefits; or

(E) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child is as follows:

(I) The plan covering the custodial parent, first;

(II) The plan covering the custodial parent's spouse, second;

(III) The plan covering the noncustodial parent, third; and then

(IV) The plan covering the noncustodial parent's spouse, last.

(iii) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined, as applicable, under (b) (i) or (ii) of this subsection as if those individuals were parents of the child.

(c) Active employee or retired or laid-off employee.

(i) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

(ii) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply.

(iii) This provision does not apply if the provision in (a) of this subsection can determine the order of benefits.

(d) COBRA or state continuation coverage.

(i) If a person whose coverage is provided under COBRA or under a right of continuation according to state or other federal

law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person under COBRA or under a right of continuation according to state or other federal law is the secondary plan.

(ii) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(iii) This provision does not apply if the provision in (a) of this subsection can determine the order of benefits.

(e) Longer or shorter length of coverage.

(i) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(ii) To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended.

(iii) The start of a new plan does not include:

(A) A change in the amount or scope of a plan's benefits;

(B) A change in the entity that pays, provides or administers the plan's benefits; or

(C) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

(iv) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date to determine the length of time the person's coverage under the present plan has been in force.

(f) If none of the preceding rules determines the order of benefits, the allowable expenses must be shared equally between the plans.

#### NEW SECTION

**WAC 284-51-210 Coordination procedures.** Issuers must use the following claims administration practices to expedite claim payments where coordination of benefits is involved:

(1) Claim personnel must participate in continuing education programs.

(2) All requests for information must be handled in an accurate and prompt manner by the inquiring issuer and the responding issuer, including the disclosure of the amounts allowed and paid or to be paid by the primary plan for each claim.

(3) Claim personnel of all issuers, whether primary or

secondary, must make every reasonable effort, including use of the telephone or e-mail, to speed up exchange of coordination of benefits information. Delay of payment for lack of complete coordination of benefits information does not constitute a reasonable effort and compliance with WAC 284-51-215 is required.

#### NEW SECTION

**WAC 284-51-215 Time limit.** Each issuer must establish time limits for payment of a claim and may not unreasonably delay payment through the application of a coordination of benefits provision. Time limits established by a primary plan must be no less favorable than those contained in WAC 284-43-321. Any time limit established by a secondary plan that is in excess of ninety days from receipt of a claim will be considered unreasonable. When payment is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage must be conducted concurrently to avoid delay in the ultimate payment of benefits. Any issuer that is required by the time limit to make payment as the primary plan because it has insufficient information to make it a secondary plan may exercise its rights under its "right of recovery" provision for recovery of any excess payments. Any issuer that is knowingly responsible for payment as the secondary plan must make a reasonable estimate of the primary plan payment and base its secondary payment on that amount. After payment information is received from the primary plan, the secondary plan may recover any excess amount paid under its "right of recovery" provision.

#### NEW SECTION

**WAC 284-51-220 Facility of payment.** A plan providing for coordination of benefits must contain a "facility of payment" provision substantially as follows: "If payments that should have been made under this plan are made by another plan, the issuer has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. To the extent of such payments, the issuer is fully discharged from liability under this plan."

NEW SECTION

**WAC 284-51-225 Right of recovery.** A plan providing for coordination of benefits must contain a "right of recovery" provision substantially as follows: "The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person, other issuer or plan that has received payment.

NEW SECTION

**WAC 284-51-230 Procedure to be followed by secondary plan to calculate benefits and pay a claim.** (1) In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim. However, in no event shall the secondary carrier be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the enrollee be responsible for a deductible amount greater than the highest of the two deductibles.

(2) If a plan by its terms contains gatekeeper requirements as defined in subsection (3) of this section, and a person fails to comply with such requirements, these provisions will have the following effect in the absence of an alternative procedure agreed upon between both plans and the covered person:

(a) If the plan is secondary, all secondary gatekeeper requirements will be waived if the gatekeeper requirements of the primary plan have been met.

(b) If the primary plan becomes secondary during a course of treatment, the new primary plan must make reasonable provision for continuity of care if one or more treating providers are not in the new primary plan's network.

(3) For the purpose of this section, "gatekeeper requirements" means any requirement that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. These requirements include but are not limited to use of network providers, prior authorization, primary care physician referrals, or other similar case management requirements.

(4) When a plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period do not exceed one hundred percent of the total allowable expenses. The secondary plan must calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary. These

savings are recorded as a benefit reserve for the covered person and must be used by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period. As each claim is submitted, the issuer of the secondary plan must:

- (a) Determine its obligation under its plan;
- (b) Determine whether a benefit reserve has been recorded for the covered person; and
- (c) Determine whether there are any unpaid allowable expenses during that claims determination period.
- (d) Use any amount that has accrued in the covered person's recorded benefit reserve to make payment so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.

#### NEW SECTION

**WAC 284-51-235 Notice to covered persons.** A plan must include the following statement in the enrollee contract or booklet provided to covered persons: "If you are covered by more than one health benefit plan, you or your provider should file all your claims with each plan at the same time. If Medicare is your primary plan, Medicare may submit your claims to your secondary carrier for you."

#### NEW SECTION

**WAC 284-51-240 Small claim waivers.** In appropriate cases, issuers are encouraged to waive the investigation of possible other plan coverage on claims less than fifty dollars. However, if additional liability is incurred which raises the claim above fifty dollars, the entire liability may be included in the coordination of benefits computation.

#### NEW SECTION

**WAC 284-51-245 Miscellaneous provisions.** (1) A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary

plan and have not already been paid or provided by the primary plan. Nothing in this provision requires a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

(2) (a) A plan with order of benefit determination rules that comply with this chapter (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this chapter (noncomplying plan) on the following basis:

(i) If the complying plan is the primary plan, it must pay or provide its benefits first;

(ii) If the complying plan is the secondary plan under the order of benefit determination in this chapter, it must pay or provide its benefits first, but the amount of the benefits payable must be determined as if the complying plan were the secondary plan. In this situation, the payment is the limit of the complying plan's liability; and

(iii) If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within forty-five days after the date on the letter making the request, the complying plan may assume the benefits of the noncomplying plan are identical to its own, and pay its benefits accordingly. If, within twenty-four months after payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it must adjust payments accordingly between the plans.

(b) If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation outlined below, then the complying plan may advance to the covered person or on behalf of the covered person an amount equal to the difference.

(c) In no event may the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan is subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan must be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.

(3) COB differs from subrogation. Provisions for one may be included in plans without compelling the inclusion or exclusion of the other.

(4) If the plans cannot agree on the order of benefits within thirty calendar days after the plans have received the information needed to pay the claim, the plans must immediately pay the claim in equal shares and determine their relative liabilities following payment. No plan is required to pay more than it would have paid had it been the primary plan.

#### NEW SECTION

**WAC 284-51-250 Applicability and scope--Effective date for existing contracts.** This chapter applies to all plans, as defined in WAC 284-51-195 that are issued, amended or renewed after December 31, 2007. All plans issued prior to January 1, 2008 must be compliant with this chapter on that date.

#### NEW SECTION

**WAC 284-51-255 Appendix A--Model COB contract provisions.  
COORDINATION OF THIS CONTRACT'S BENEFITS  
WITH OTHER BENEFITS**

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits according to its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

#### **DEFINITIONS**

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

(1) **Plan** includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment

coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the **Total Allowable expense** for that claim. This means that when this **Plan** is **Secondary**, it must pay the amount which, when combined with what the **Primary plan** paid, totals 100% of the highest **Allowable expense**. In addition, if this **Plan** is **Secondary**, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the **Primary plan**) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an **Allowable expense** under this **Plan**. If this **Plan** is **Secondary**, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room



expenses.

(2) If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(3) If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

#### **ORDER OF BENEFIT DETERMINATION RULES**

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

B. (1) Except as provided in subsection (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the **Plan** provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the

person as other than a dependent (e.g., a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

- If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to claim determination periods commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or

(v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The **Plan** covering the **Custodial parent**, first;
- The **Plan** covering the spouse of the **Custodial parent**, second;
- The **Plan** covering the **non-custodial parent**, third; and then
- The **Plan** covering the spouse of the **non-custodial parent**, last

(c) For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan**

that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** must be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

#### **EFFECT ON THE BENEFITS OF THIS PLAN**

When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a claim determination period are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total **Allowable expense** for that claim **Total Allowable expense** is the highest **Allowable expense** of the **Primary plan** or the **Secondary plan**. In addition, the **Secondary plan** must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

#### **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. [Organization responsibility for **COB** administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. [Organization

responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give [Organization responsibility for COB administration] any facts it needs to apply those rules and determine benefits payable.

#### **FACILITY OF PAYMENT**

If payments that should have been made under **This plan** are made by another **Plan**, the issuer has the right, at its discretion, to remit to the other **Plan** the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other **Plan** are considered benefits paid under **This plan**. To the extent of such payments, the issuer is fully discharged from liability under **This plan**.

#### **RIGHT OF RECOVERY**

The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

**Questions about Coordination of Benefits?  
Contact Your State Insurance Department**

#### NEW SECTION

**WAC 284-51-260 Appendix B--Consumer explanatory booklet.  
COORDINATION OF BENEFITS**

##### **IMPORTANT NOTICE**

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

##### **Double Coverage**

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all

plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

### **Primary or Secondary?**

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim. Any plan that does not contain your state's COB rules will always be primary.

### **When This Plan is Primary**

If you or a family member is covered under another plan in addition to this one, we will be primary when:

#### **Your Own Expenses**

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

#### **Your Spouse's Expenses**

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

- **Your Child's Expenses.** The claim is for the health care expenses of your child who is covered by this plan; and

- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or

- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or

- There is no court decree, but you have custody of the child.

#### **Other Situations**

We will be primary when any other provisions of state or federal law require us to be.

### **How We Pay Claims When We Are Primary**

When we are the primary plan, we will pay the benefits according to the terms of your contract, just as if you had no other health care coverage under any other plan.

### **How We Pay Claims When We Are Secondary**

When we are knowingly the secondary plan, we will make a reasonable estimate of the primary plan payment and base our payment on that amount. After payment information is received from the primary plan, we may recover from the primary plan any excess

amount paid under the "right of recovery" provision in the plan. We may not delay our payments because of lack of information from the primary plan. We are required to pay claims within ninety days of receipt.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other plans.

- We will determine our payment by subtracting the amount we estimate that the primary plan will pay from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal to one hundred percent of the total allowable expense (the highest of the amounts allowed under each plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

**Questions About Coordination of Benefits?**  
**Contact Your State Insurance Department**

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 284-51-010	Purpose and scope.
WAC 284-51-015	Amount of reduction allowed.
WAC 284-51-020	Required provisions for coordination of benefits.
WAC 284-51-030	Benefits subject to coordination.
WAC 284-51-040	"Plan" defined.
WAC 284-51-045	"Preventive care" defined.
WAC 284-51-050	Allowable expense.
WAC 284-51-060	Claim determination period.
WAC 284-51-075	Order of benefit determination.
WAC 284-51-080	Determination of length of coverage.
WAC 284-51-090	Coordination procedures.
WAC 284-51-100	Time limit.
WAC 284-51-110	Small claim waivers.
WAC 284-51-120	Facility of payment.
WAC 284-51-130	Right of recovery.
WAC 284-51-140	Right to receive and release necessary information.
WAC 284-51-150	Disclosure of coordination.
WAC 284-51-170	Effective date.
WAC 284-51-185	Appendix B, form for "effect on benefits" provision.